FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042861

Facility Name: Provena Villa Franciscan

Address: 210 N. Springfield (Number) Joliet (City) 60435 (Zip Code)

County: Will

Telephone Number: (815)725-3400 **Fax #** (815)725-2160

IDPA ID Number: 371127787008

Date of Initial License for Current Owners: 12/01/97

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501c3

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708)478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed) _____ (Date)
	(Type or Print Name) Michael R Gordon
	(Title) Vice President
Paid Preparer	(Signed) _____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 4/1/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	176	Skilled (SNF)	136	53,240	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)	40	11,000	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,703	824	11,348	37,875	8
9	SNF/PED					9
10	ICF		18,062		18,062	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,703	18,886	11,348	55,937	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.08%

D. How many bed-hold days during this year were paid by Public Aid? 10 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 46 and days of care provided 11,348

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	327,740	25,140	32,470	385,350		385,350		385,350			1
2	Food Purchase		273,610		273,610		273,610	2,689	276,299			2
3	Housekeeping	152,170	47,475	760	200,405		200,405		200,405			3
4	Laundry	50,824	93	163,148	214,065		214,065	(35,771)	178,294			4
5	Heat and Other Utilities			166,929	166,929		166,929	5,423	172,352			5
6	Maintenance	112,718	16,630	83,111	212,459		212,459	655	213,114			6
7	Other (specify):* Pastoral Care/Develop	40,900	532	639	42,071		42,071	(6,621)	35,450			7
8	**TOTAL General Services**	684,352	363,480	447,057	1,494,889		1,494,889	(33,625)	1,461,264			8
	B. Health Care and Programs											
9	Medical Director			16,846	16,846		16,846		16,846			9
10	Nursing and Medical Records	2,696,294	214,712	1,068,951	3,979,957		3,979,957		3,979,957			10
10a	Therapy			535,814	535,814		535,814		535,814			10a
11	Activities	126,461	5,282	26,861	158,604		158,604		158,604			11
12	Social Services	111,174			111,174		111,174		111,174			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,933,929	219,994	1,648,472	4,802,395		4,802,395		4,802,395			16
	C. General Administration											
17	Administrative	233,586	61,030	752,874	1,047,490		1,047,490	(394,275)	653,215			17
18	Directors Fees											18
19	Professional Services			181,625	181,625		181,625	16,266	197,891			19
20	Dues, Fees, Subscriptions & Promotions			70,365	70,365		70,365	(10,932)	59,433			20
21	Clerical & General Office Expenses		24,410	43,320	67,730		67,730	(7,142)	60,588			21
22	Employee Benefits & Payroll Taxes			855,290	855,290		855,290	56,096	910,916			22
23	Inservice Training & Education			7,345	7,345		7,345	8,352	15,697			23
24	Travel and Seminar			4,701	4,701		4,701	5,511	10,435			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			84,486	84,486		84,486		84,486			26
27	Other (specify):* Bad Debt Expense			94,565	94,565		94,565	(94,565)				27
28	**TOTAL General Administration**	233,586	85,440	2,094,571	2,413,597		2,413,597	(420,689)	1,992,661			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,851,867	668,914	4,190,100	8,710,881		8,710,881	(454,314)	8,256,320			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena Villa Franciscan #0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			338,298	338,298		338,298	31	338,329			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							200,321	200,321			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							15,812	15,812			34
35	Rent-Equipment & Vehicles			85,176	85,176		85,176	1,297	86,473			35
36	Other (specify):*											36
37	**TOTAL Ownership**			423,474	423,474		423,474	217,461	640,935			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			962,197	962,197		962,197		962,197			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,364	96,364		96,364		96,364			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,058,561	1,058,561		1,058,561		1,058,561			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,851,867	668,914	5,672,135	10,192,916		10,192,916	(236,853)	9,955,816			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(35,771)	4		8
9	Non-Straightline Depreciation	(3,446)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(14,227)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(30)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(94,565)	27		24
25	Fund Raising, Advertising and Promotional	(18,089)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (166,128)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(62,471)	VAR	34
35	Other- Attach Schedule	(8,254)	VAR	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (70,725)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (236,853)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Provena Villa Franciscan

ID# 0042861

Report Period Beginning: 1/1/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Food	$ (30)	2	1
2	Development Minor Equipment	(126)	6	2
3	Development Supplies	336	17	3
4	Development Misc	(3,526)	17	4
5	Development Events/Activities	(10)	17	5
6	Development Consulting	1,043	19	6
7	Development Supplies	193	21	7
8	Development Benefits	470	22	8
9	Development Conference	240	23	9
10	Development Travel	(223)	24	10
11	Development Salaries	(6,621)	7	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,254)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Provena Villa Franciscan **#** 0042861 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(30)	2,719	0	0	0	0	0	0	0	0	0	2,689	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(35,771)	0	0	0	0	0	0	0	0	0	0	(35,771)	4
5	Heat and Other Utilities	0	5,423	0	0	0	0	0	0	0	0	0	5,423	5
6	Maintenance	(126)	781	0	0	0	0	0	0	0	0	0	655	6
7	Other (specify):*	(6,621)	0	0	0	0	0	0	0	0	0	0	(6,621)	7
8	**TOTAL General Services**	(42,548)	8,923	0	0	0	0	0	0	0	0	0	(33,625)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(3,230)	(391,045)	0	0	0	0	0	0	0	0	0	(394,275)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	1,043	15,223	0	0	0	0	0	0	0	0	0	16,266	19
20	Fees, Subscriptions & Promotions	(18,089)	7,157	0	0	0	0	0	0	0	0	0	(10,932)	20
21	Clerical & General Office Expenses	(14,034)	6,892	0	0	0	0	0	0	0	0	0	(7,142)	21
22	Employee Benefits & Payroll Taxes	470	55,626	0	0	0	0	0	0	0	0	0	56,096	22
23	Inservice Training & Education	240	8,112	0	0	0	0	0	0	0	0	0	8,352	23
24	Travel and Seminar	(223)	5,734	0	0	0	0	0	0	0	0	0	5,511	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(94,565)	0	0	0	0	0	0	0	0	0	0	(94,565)	27
28	**TOTAL General Administration**	(128,388)	(292,301)	0	0	0	0	0	0	0	0	0	(420,689)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(170,936)	(283,378)	0	0	0	0	0	0	0	0	0	(454,314)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Villa Franciscan # 0042861 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(3,446)	0	3,477	0	0	0	0	0	0	0	0	31	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	200,321	0	0	0	0	0	0	0	0	200,321	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	15,812	0	0	0	0	0	0	0	0	15,812	34
35	Rent-Equipment & Vehicles	0	0	1,297	0	0	0	0	0	0	0	0	1,297	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,446)	0	220,907	0	0	0	0	0	0	0	0	217,461	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(174,382)	(283,378)	220,907	0	0	0	0	0	0	0	0	(236,853)	45

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food Purchase	$	Provena Senior Services	100.00%	$ 2,719	$ 2,719	1
2	V	3	Housekeeping - Supplies		Provena Senior Services	100.00%	0		2
3	V	5	Heat & Other Utilities		Provena Senior Services	100.00%	5,423	5,423	3
4	V	6	Maintenance - Other		Provena Senior Services	100.00%	781	781	4
5	V	17	Admin Salary Other Admin		Provena Senior Services	100.00%	185,889	185,889	5
6	V	17	Admin - Other	610,123	Provena Senior Services	100.00%	33,189	(576,934)	6
7	V	19	Professional Services		Provena Senior Services	100.00%	15,223	15,223	7
8	V	20	Dues, Fees, Subs & Promotions		Provena Senior Services	100.00%	7,157	7,157	8
9	V	21	Clerical/Genl Supplies		Provena Senior Services	100.00%	4,556	4,556	9
10	V	21	Clerical/Gen - Other		Provena Senior Services	100.00%	2,336	2,336	10
11	V	22	Emp Benefits & Payroll Taxes		Provena Senior Services	100.00%	55,626	55,626	11
12	V	23	Inservice Training & Education		Provena Senior Services	100.00%	8,112	8,112	12
13	V	24	Travel & Seminar		Provena Senior Services	100.00%	5,734	5,734	13
14	Total			$ 610,123			$ 326,745	$ * (283,378)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Provena Senior Services		$ 3,477	$ 3,477	15
16	V	32	Interest		Provena Senior Services		200,321	200,321	16
17	V	34	Rent - Facility & Grounds		Provena Senior Services		15,812	15,812	17
18	V	35	Rent - Equipment & Vehicles		Provena Senior Services		1,297	1,297	18
19	V	17	Admin - Other	141,719	Provena Health		141,719		19
20	V	19	Professional Services	100,058	Provena Health		100,058		20
21	V	39	Ancillary Service Centers - Other	962,197	Provena Senior Services Pharmacy		962,197		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,203,974			$ 1,424,881	$ * 220,907	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	Mgmt Fee Income	5,373,327	16	$ 23,945	$	610,123	$ 2,719	1
2	3	Housekeeping - Supplies	Mgmt Fee Income	5,373,327	16	(3)		610,123	0	2
3	5	Heat & Other Utilities	Mgmt Fee Income	5,373,327	16	47,756		610,123	5,423	3
4	6	Maintenance - Other	Mgmt Fee Income	5,373,327	16	6,877		610,123	781	4
5	17	Admin Salary Other Admin	Mgmt Fee Income	5,373,327	16	1,637,117	1,637,117	610,123	185,889	5
6	17	Admin - Other	Mgmt Fee Income	5,373,327	16	292,291		610,123	33,189	6
7	19	Professional Services	Mgmt Fee Income	5,373,327	16	134,066		610,123	15,223	7
8	20	Dues, Fees, Subs & Promotions	Mgmt Fee Income	5,373,327	16	63,031		610,123	7,157	8
9	21	Clerical/Genl Supplies	Mgmt Fee Income	5,373,327	16	40,128		610,123	4,556	9
10	21	Clerical/Gen - Other	Mgmt Fee Income	5,373,327	16	20,574		610,123	2,336	10
11	22	Emp Benefits & Payroll Taxes	Mgmt Fee Income	5,373,327	16	489,898		610,123	55,626	11
12	23	Inservice Training & Education	Mgmt Fee Income	5,373,327	16	71,446		610,123	8,112	12
13	24	Travel & Seminar	Mgmt Fee Income	5,373,327	16	50,497		610,123	5,734	13
14	30	Depreciation	Mgmt Fee Income	5,373,327	16	30,618		610,123	3,477	14
15	32	Interest	Mgmt Fee Income	5,373,327	16	1,764,218		610,123	200,321	15
16	34	Rent - Facility & Grounds	Mgmt Fee Income	5,373,327	16	139,255		610,123	15,812	16
17	35	Rent - Equipment & Vehicles	Mgmt Fee Income	5,373,327	16	11,422		610,123	1,297	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,823,136	$ 1,637,117		$ 547,652	25

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfurt, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin - Other	Direct Allocaton			$	$		$ 141,719	1
2	19	Professional Services	Direct Allocaton						100,058	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 241,777	25

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocaton			$	$		$ 962,197	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 962,197	25

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										200,321	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 200,321	14
15	TOTALS (line 9+line14)						$	$			$ 200,321	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena Villa Franciscan COUNTY Will

FACILITY IDPH LICENSE NUMBER 0042861

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1990	$ 285,994	1
2					2
3	TOTALS			$ 285,994	3

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1990	1990	$ 6,780,910	$ 219,859	25	$ 219,859	$	$ 2,839,415	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1991	2,510	126	20	126		1,465	9
10	VARIOUS			1992	57,831	2,666	20	2,666		34,978	10
11	VARIOUS			1993	34,723	2,203	20	2,203		20,458	11
12	VARIOUS			1994	32,574	1,814	20	1,814		17,914	12
13	VARIOUS			1995	85,665	3,601	20	3,601		35,895	13
14	VARIOUS			1996	46,885	2,517	20	2,517		30,879	14
15	VARIOUS			1997	18,743	1,105	20	1,105		12,708	15
16	VARIOUS			1998	21,439	2,144	20	2,144		21,439	16
17	VARIOUS			1999	4,936	744	20	744		3,348	17
18											18
19	DESC: SMOKE DETECTOR W/MODULE & STROBES			2000	1,756	351	5	351		1,229	19
20	DESC: COMMUNICATION CABLES			2000	990	198	5	198		693	20
21	DESC: DISHMACH CONVYR, VENT COWLS/COLLARS			2000	5,933	848	7	848		2,967	21
22	DESC: RGB MAJOR BUILDING CONSULTING			2000	5,712	571	10	571		1,999	22
23	DESC: VLF COMMON AREA ASSESSMENT			2000	4,543	909	5	909		3,180	23
24	DESC: HOT WATER HEATER			2000	11,470	1,147	10	1,147		4,015	24
25	DESC: IMTERFACE SMOKE DAMPERS TO FIRE ALAR			2000	8,600	1,720	5	1,720		6,020	25
26	DESC: FIRE AND SMOKE DAMPERS			2000	26,652	3,807	7	3,807		13,326	26
27	DESC: ELECTRICAL WIRING FIRE DAMPERS			2000	7,382	1,476	5	1,476		5,167	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DESC: CARPET	2001	$ 1,565	$ 313	5	$ 313	$	$ 783	37
38	DESC: RELOCATE NURSE CALL SYSTEM	2001	2,576	515	5	515		1,288	38
39	DESC: CONVEYOR TOASTER	2001	590	118	5	118		295	39
40	DESC: RESIDENT ROOM DOOR CLOSER	2001	1,255	251	5	251		628	40
41	DESC: REPLACE 3 GAS SHUT OFF VAVLES	2001	989	198	5	198		495	41
42	DESC: CARPET	2001	3,298	660	5	660		1,649	42
43	DESC: DRIVEWAY, BLACKTOPPING	2001	2,900	725	2	725		2,900	43
44	DESC: GARBAGE DISPOSAL	2002	875	175	5	175		263	44
45	DESC: CARPET FOR ELEVATORS	2002	1,831	366	5	366		366	45
46	DESC: ACCESS CONTROL TO FIRE ALARM	2002	3,150	315	10	315		473	46
47	DESC: INSTALLATION OF DOME CAMERA	2002	2,346	469	5	469		704	47
48	DESC: CCTV	2003	3,910	391	5	391		391	48
49	DESC: MCQUAY COMPRESSOR FOR KITCHEN UNIT	2003	3,629	151	12	151		151	49
50	DESC: MURAL DAMIANO UNIT	2003	1,850	185	5	185		185	50
51	DESC: RELIEF VALVE FOR REFRIGERATION SYSTE	2003	2,735	195	7	195		195	51
52	DESC: STAINED GLASS WINDOW FOR CHAPEL	2003	1,575	79	10	79		79	52
53	DESC: SECURITY SYSTEM	2003	3,390	170	10	170		170	53
54	DESC: MURAL	2003	3,000	300	5	300		300	54
55	DESC: SELONOID FOR HOT WATER TANK	2003	985	49	10	49		49	55
56	DESC: WANDER GUARD SYSTEM	2003	1,853	62	15	62		62	56
57	DESC: REPAIR REACH-IN FREEZER	2003	2,764	138	10	138		138	57
58	DESC: ALARM SYSTEM	2003	3,860	193	10	193		193	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,210,181	$ 253,824		$ 253,824	$	$ 3,068,851	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 784,624	$ 79,155	$ 79,155	$	10	$ 544,296	71
72	Current Year Purchases	108,656	5,350	5,350		10	5,350	72
73	Fully Depreciated Assets	749,207					749,207	73
74								74
75	TOTALS	$ 1,642,487	$ 84,505	$ 84,505	$		$ 1,298,853	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,138,662	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 338,329	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 338,329	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,367,704	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation - Home Office				15,812			5
6								6
7	TOTAL				$ 15,812 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 86,473 Description: Nursing $82,280, Activities $26, Dietary $26, Plant Eng $502, Laundry $490, Admin $1,852, Home Office $1,297
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	3,701	$	193,193	$	3,701	$ 193,193	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,700		88,715		1,700	88,715	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a, 3	hrs		4,864		253,906	7,839	4,864	261,745	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts					962,197		962,197	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	10,265	$	535,814	$ 970,036	10,265	$ 1,505,850	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,794,696	$	1
2	Cash-Patient Deposits	77,816		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	10,376,541		3
4	Supply Inventory (priced at)	485,379		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,788		6
7	Other Prepaid Expenses	803,877		7
8	Accounts Receivable (owners or related parties)	251,746		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 20,809,843	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,263,715		12
13	Land	6,877,199		13
14	Buildings, at Historical Cost	72,927,547		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	13,543,467		16
17	Accumulated Depreciation (book methods)	(39,708,360)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	38,281		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	147,576		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 61,089,425	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 81,899,268	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,893,009	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,831,666		28
29	Short-Term Notes Payable	1,152,937		29
30	Accrued Salaries Payable	2,954,499		30
31	Accrued Taxes Payable (excluding real estate taxes)	123,166		31
32	Accrued Real Estate Taxes(Sch.IX-B)	320,867		32
33	Accrued Interest Payable	24,581		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	50,095		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,350,820	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	41,981,938		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	102,004		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 42,083,942	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 50,434,762	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,464,506	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 81,899,268	$	48

***(See instructions.)**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 33,384,592	1
2	Restatements (describe):		2
3	**2002 Goodwill Write off per Audit**	(3,481,389)	3
4	**Adj. To Reconcile Consolidated Equity and Consolidated**		4
5	**Net Income to Nursing Facility Amounts**	1,983,138	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 31,886,341	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(421,835)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (421,835)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 31,464,506	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,611,193	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,611,193	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,139,726	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,139,726	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	18,446	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	905,681	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	29,261	20
21	Other Medical Services		21
22	Laundry	35,771	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 989,159	23
	D. Non-Operating Revenue		
24	Contributions	9,118	24
25	Interest and Other Investment Income***	62	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,180	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	21,023	28
28a	Gain on Disposal of Assets	800	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,823	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,771,081	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,494,889	31
32	Health Care	4,802,395	32
33	General Administration	2,413,597	33
	B. Capital Expense		
34	Ownership	423,474	34
	C. Ancillary Expense		
35	Special Cost Centers	962,197	35
36	Provider Participation Fee	96,364	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,192,916	40
41	**Income before Income Taxes (line 30 minus line 40)****	(421,835)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (421,835)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,776	1,920	$ 61,354	$ 31.96	1
2	Assistant Director of Nursing	1,512	1,641	46,903	28.58	2
3	Registered Nurses	21,745	23,007	574,170	24.96	3
4	Licensed Practical Nurses	33,313	35,668	657,009	18.42	4
5	Nurse Aides & Orderlies	108,218	115,314	1,294,925	11.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,150	5,609	61,933	11.04	8
9	Activity Director	1,936	2,107	41,705	19.79	9
10	Activity Assistants	8,036	8,984	84,756	9.43	10
11	Social Service Workers	6,920	7,740	111,174	14.36	11
12	Dietician					12
13	Food Service Supervisor	3,788	4,144	61,096	14.74	13
14	Head Cook	6,179	6,598	65,448	9.92	14
15	Cook Helpers/Assistants	23,441	25,186	201,196	7.99	15
16	Dishwashers					16
17	Maintenance Workers	7,775	8,555	112,718	13.18	17
18	Housekeepers	16,554	17,771	152,170	8.56	18
19	Laundry	5,458	5,925	50,824	8.58	19
20	Administrator	1,680	1,880	76,243	40.55	20
21	Assistant Administrator	1,288	1,328	40,345	30.38	21
22	Other Administrative	5,285	5,652	76,869	13.60	22
23	Office Manager					23
24	Clerical	4,372	4,678	40,129	8.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral/Developm	2,136	2,232	40,900	18.32	33
34	TOTAL (lines 1 - 33)	266,562	285,939	$ 3,851,867 *	$ 13.47	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	288	$ 21,306		35
36	Medical Director	$1,100/mth	16,846		36
37	Medical Records Consultant	312	15,608		37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,112		44
45	Social Service Consultant	22	1,251		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	642	$ 56,123		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,439	$ 321,178		50
51	Licensed Practical Nurses	10,947	412,054		51
52	Nurse Aides	13,729	302,730		52
53	TOTAL (lines 50 - 52)	31,115	$ 1,035,961		53

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alice Giese	Admin		$ 44,973
Ann Dodge	Admin		31,270
Other	Other Admin		157,343
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 233,586

B. Administrative - Other

Description	Amount
Miscellaneous	$ 1,032
Corp Service Fee	141,719
Mgmt Fee	452,707
Mgmt Fee Interest	157,416
TOTAL (agree to Schedule V, line 17, col. 3)	$ 752,874
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees		$ 33
Legal Fees		3,268
Accounting		2,309
Purchased Service		457
Consulting		15,608
Consulting		21,306
Consulting		35,094
Consulting		100,058
Consulting		3,492
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 181,625

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,048
Unemployment Compensation Insurance	21,167
FICA Taxes	283,073
Employee Health Insurance	308,320
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	160,682
Home Office Allocation	55,626
TOTAL (agree to Schedule V, line 22, col.8)	$ 910,916

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 111)	
Dues & Subscriptions	70,365
Advertising & Public Relations	
Home Office Allocation	7,157
Less: Public Relations Expense	( )
Non-allowable advertising	(18,089)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 59,433

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,701
Seminar Expense	
Home Office Allocation	5,734
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,435

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **7219 - Life Services Network**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **176**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,482** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **96,364**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **N/A**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Provena Villa Franciscan
0042861
Attachment for Related Facilities
12/31/2003

Related Nursing Homes

Facility Name	City
Provena Our Lady of Victory	Bourbonnais
Provena Pine View Care Center	St. Charles
Provena Geneva Care Center	Geneva
Provena Cor Mariae Center	Rockford
Provena St. Joseph Center	Freeport
Provena McAuley Manor	Aurora
Provena St. Anne Center	Rockford
Provena Villa Franciscan	Joliet
Provena Heritage Village	Kankakee

Related Business Entities

Facility Name	City	Notes
Provena Clinics		Physician's Clinics
Provena Fortin Villa Learning Cer	Bourbonnais	Childrens Center
Provena Fox Knoll	Aurora	Retirement Community
Provena Health	Frankfurt	Parent Company
Provena Home Care		Home Health
Provena Home Equipment		Home Equipment
Provena Hospice		Hospice
Provena Hospitals		Hospital
Provena Laverna Terrace	Avilla, IN	Independent Living
Provena Meadowview Lodge	Kankakee	Supportive Living
Provena Senior Services	Mokena	Management Company
Provena Senior Services Pharma	Kankakee	Pharmacy
Provena St. Joseph Adult Day Ca	Freeport	Adult Day Care
Provena St. Mary's Adult Day Cai	Kankakee	Adult Day Care
Provena St. Vincent	Freeport	Community Living
St. Anne's Place	Rockford	Independent Living

5/31/2014	53101	DISCOUNT TAKEN	(552)
mar7	5-2456-3	PTAX OUT OF STATE SALES TAX	38.48
mar7	5-2456-3	PTAX OUT OF ST SALES TAX ON FUEL & OTHER	(38.61)
mar7	5-2456-3	PTAX OUT OF STATE SALES TAX ON FUEL & OTHER	38.61
mar7	5-2456-3	PTAX OUT OF STATE SALES TAX ON FUEL & OTHER	(38.61)
mar7	5-2456-3	PTAX OUT OF STATE SALES TAX ON FUEL & OTHER	38.61
mar7	5-2456-3	PTAX OUT OF STATE SALES TAX ON FUEL & OTHER	41,340.24
mar7	5-2456-3	PTAX OUT OF STATE SALES TAX ON FUEL & OTHER	(41,340.24)
mar7	5-2456-3	PTAX OUT OF SALES TAX ON FUEL & OTHER	38.61
mar7	5-2456-3	PTAX OUT OF STATE SALES TAX ON FUEL & OTHER	(38.61)
	5-2456-3 Total		0.00
4/14/2014	5-2456-3	PTAX OUT SALES AND REFUNDS	101,487.72
4/14/2014	5-2456-3	PTAX OUT SALES AND REFUNDS - OTHER STATE A	1,000.00
	5-2456-3 Total		102,487.72
2/14/2014	5-2456-3	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	5-2456-3 Total		(2,000.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
5/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/SUSP. LEASED ENERGY	(2,000.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
5/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
5/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
5/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
5/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
5/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
5/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	5/31/2014 Total		(15,000,000.00)
5/31/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
5/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
5/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
5/31/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
5/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
5/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	5/31/2014 Total		(15,000,000.00)
7/31/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
7/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
7/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
7/31/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
7/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
7/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	7/31/2014 Total		(15,000,000.00)
7/31/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
7/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
7/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
7/31/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
7/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
7/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	7/31/2014 Total		(15,000,000.00)
8/31/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
8/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
8/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
8/31/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
8/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
8/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	8/31/2014 Total		(15,000,000.00)
9/30/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
9/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
9/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
9/30/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
9/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
9/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	9/30/2014 Total		(15,000,000.00)
10/31/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
10/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
10/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
10/31/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
10/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
10/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	10/31/2014 Total		(15,000,000.00)
11/30/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
11/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
11/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
11/30/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
11/30/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
11/30/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	11/30/2014 Total		(15,000,000.00)
12/31/2014	53101	PTAX OUT SALES AND REFUNDS	(3,647,727.00)
12/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
12/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
12/31/2014	53101	PTAX OUT SALES AND REFUNDS	(370,238.00)
12/31/2014	53101	PTAX OUT SALES AND REFUNDS - OTHER STATE	(1,000.00)
12/31/2014	53101	PTAX OUT RETURNS/BAD DEBTS/ SUSP. LEASED ENERGY	(2,000.00)
	12/31/2014 Total		(15,000,000.00)
	Grand Total		(210,000,000.00)